EDMUND G. BROWN JR., Attorney General
of the State of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
LORETTA A. WEST
Deputy Attorney general, BAR No. 149294

110 West "A" Street, Suite 1100
San Diego, CA 92101

P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-3037
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DAVID ORVILLE ROARK** 277 Geremma Drive Ballwin, MO 63011 Registered Nurse License No. 538709 Respondent.	Case No. 2009-109 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about November 21, 1997, the Board issued Registered Nurse License Number 538709 to David Orville Roark ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2009, unless renewed.

///

STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761, subdivision (a), states that the Board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022. . .
>
> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Code section 4060 states:

> No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a

manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

8. Health and Safety Code ("Health & Saf. Code") section 11173, subdivision (a), states, in pertinent part, that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances by fraud, deceit, misrepresentation or subterfuge.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

10. "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

11. "Vicodin" is a compound consisting of 5 mg hydrocodone bitartrate, also known as dihydrocodeinone, and 500 mg acetaminophen per tablet, and is a Schedule III controlled substance as designated by Health and Saftey Code section 11056, subdivision (e)(4).

FIRST CAUSE FOR DISCIPLINE

(Out-of-State Disciplinary Action)

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct. On or about June 13, 2006, pursuant to the Voluntary Surrender of License in Lieu of Other Disciplinary Action ("Voluntary Surrender"), accepted and approved by the Nevada State Board of Nursing, in the disciplinary proceeding titled *In the Matter of David Roark Licensed Professional Nurse Nevada License No. RN41470*, Case No. 1238-05C, Respondent voluntarily surrendered his license to practice

registered nursing in the state of Nevada. Respondent admitted that in November and December 2005, while employed as a registered nurse at Sunrise Hospital, he diverted Lortab while on duty. A true and correct copy of the Voluntary Surrender is attached as Exhibit "A" and incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Diversion and Possession of Controlled Substances)

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that on or about and between October 27, 2006, and November 25, 2006, while employed by On Assignment, a traveling nurse registry in Tupelo, Mississippi, and assigned to work in the emergency room at Riverside County Regional Medical Center in Moreno Valley, California (hereinafter "RCRMC"), Respondent did the following:

Diversion of Controlled Substances:

a. Respondent obtained the controlled substances Vicodin and Morphine by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: On and between October 27, 2006, and November 25, 2006, Respondent removed varying quantities of Vicodin and Morphine from the Pyxis under the names of several different patients when there were no physicians' orders authorizing the medications for the patients, or the quantities of the medications removed from the Pyxis were in excess of the doses ordered by the patients' physicians. Further, Respondent failed to chart the administration or wastage of the Vicodin and Morphine in the Medication Summaries and/or Nursing Notes or falsified or made grossly incorrect, grossly inconsistent, or unintelligible entries in the Medication Administration Record ("MAR") or Nurse's Notes/Flowsheet ("NNF") to conceal his diversion of the Vicodin and Morphine, as more particularly set forth in paragraph 14 below.

///

///

///

Possession of Controlled Substances:

b. On and between October 27, 2006, and November 25, 2006, Respondent possessed unknown quantities of the controlled substances Vicodin and Morphine without a valid prescription from a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor, in violation of Code section 4060.

THIRD CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that on and between October 27, 2006, and November 25, 2006, while assigned to work as a registered nurse in the emergency room of RCRMC in Moreno Valley, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substances Vicodin and Morphine, as follows:

a. On November 12, 2006, at 0634 hours, Respondent removed one tablet of Vicodin from the Pyxis under Patient #1's name when, in fact, there was no physician's order for the medication. Further, Respondent failed to chart the administration of the medication to the patient until being confronted with the discrepancy, and then made a late entry in the patient's chart showing that he had administered the medication at 0620 hours.

b. On November 25, 2006, at 2342 hours, Respondent removed two doses of Morphine 2 mg from the Pyxis under Patient #2's name when, in fact, there was no physician's order for the medication. Further, Respondent entered into the Pyxis that he had removed only one dose of Morphine 2 mg when, in fact, he had removed two doses. In addition, Respondent failed to chart the administration or wastage of the two doses of Morphine 2 mg in the patient's MAR or NNF or otherwise account for the disposition of the medication.

///

///

///

c. On November 10, 2006, at 0654 hours, Respondent removed two tablets of Vicodin from the Pyxis under Patient #3's name when, in fact, there was no physician's order for the medication. Respondent documented that the medication was wasted through the Pyxis at 0658 hours.

d. On November 11, 2006, at 2019 hours, Respondent removed two tablets of Vicodin from the Pyxis under Patient #4's name when, in fact, there was no physician's order for the medication. Further, Respondent failed to chart the administration or wastage of the two tablets of Vicodin in the patient's MAR or NNF or otherwise account for the disposition of the medication. In addition, the patient had been discharged from the hospital that day at 1320 hours.

e. On October 27, 2006, at 2311 hours, Respondent removed two tablets of Vicodin from the Pyxis under Patient #5's name when, in fact, there was no physician's order for the medication. Further, Respondent did not document that the medication was wasted through the Pyxis until 0019 hours. In addition, Respondent was not assigned to care for the patient and, according to the chart, the patient was noted to be undergoing a CT scan at 2310 hours.

f. On November 10, 2006, at 0530 hours, Respondent removed two tablets of Vicodin from the Pyxis under Patient #6's name when, in fact, there was no physician's order for the medication. Respondent did not document that the medication was wasted through the Pyxis until 0634 hours.

g. On November 11, 2006, at 0536 hours, Respondent removed two Vicodin tablets from the Pyxis under Patient #7's name when, in fact, there was no physician's order for the medication. Further, Respondent failed to chart the administration or wastage of the two tablets of Vicodin in the patient's MAR or NNF or otherwise account for the disposition of the medication. In addition, Respondent was not assigned to care for the patient.

h. On November 9, 2006, at approximately 2340 hours, Respondent removed two tablets of Vicodin from the Pyxis under Patient #8's name. Respondent failed to chart the administration or wastage of the two tablets of Vicodin in the patient's MAR or NNF or otherwise account for the disposition of the medication. Prior to Respondent's removal of the

Vicodin from the Pyxis, another nurse in the emergency room had administered Vicodin to the patient at approximately 1830 hours. Further, Respondent was not assigned to care for the patient and had not received a subsequent physician's order for the medication.

i. On November 12, 2006, at approximately 0634 hours, Respondent removed two tablets of Vicodin from the Pyxis under Patient #9's name. Respondent entered into the Pyxis that he had removed only one tablet of Vicodin, when, in fact, he had removed two. Further, Respondent failed to chart the administration or wastage of the two tablets of Vicodin in the patient's MAR or NNF or otherwise account for the disposition of the medication.

j. On November 10, 2006, at approximately 2017 hours, Respondent removed two tablets of Vicodin from the Pyxis under Patient #11's name when, in fact, there was no physician's order for the medication. Further, Respondent failed to chart the administration or wastage of the two tablets of Vicodin in the patient's MAR or NNF or otherwise account for the disposition of the medication. In addition, Respondent was not assigned to care for the patient and the patient had not been in the emergency room since 1030 hours that day.

k. On November 19, 2006, at approximately 2154 hours, Respondent removed two tablets of Vicodin under Patient #12's name when, in fact, there was no physician's order for the medication. Further, Respondent failed to chart the administration or wastage of the two tablets of Vicodin in the patient's MAR or NNF or otherwise account for the disposition of the medication. In addition, Respondent was not assigned to care for the patient and the patient had not been in the emergency room since 1015 hours that day.

l. On November 11, 2006, at approximately 2118 hours, Respondent removed two tablets of Vicodin under Patient #13's name. Respondent failed to chart the administration or wastage of the two tablets of Vicodin in the patient's MAR or NNF or otherwise account for the disposition of the medication.

m. On November 11, 2006, at approximately 0138 hours, Respondent removed two tablets of Vicodin under Patient #14's name. A physician's order for the medication was not given until 0150 hours that day. Respondent did not chart the administration of the medication to the patient until 0150 hours that day.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 538709, issued to David Orville Roark;

2. Ordering David Orville Roark to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 11/17/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

clp; 9/10/08
Roark, David.acc

EXHIBIT "A"

VOLUNTARY SURRENDER OF LICENSE

IN LIEU OF OTHER DISCIPLINARY ACTION

ORIGINAL

BEFORE THE NEVADA STATE BOARD OF NURSING

IN THE MATTER OF
DAVID ROARK
LICENSED PROFESSIONAL NURSE
NEVADA LICENSE NO. RN41470
RESPONDENT

COMPLAINT AND NOTICE OF HEARING

CASE NO. 1238-05C

The Nevada State Board of Nursing (Board), by and through counsel, Frederick R. Olmstead, hereby notifies Respondent David Roark of an administrative hearing, which is to be held pursuant to Chapters 233B and 632 of the Nevada Revised Statutes and Chapter 632 of the Nevada Administrative Code. The purpose of the hearing is to consider the allegations stated below and to determine if the Respondent should be subject to an administrative penalty as set forth in NRS 632.320 and/or NRS 632.325 and/or NAC 632.926-.927, if the stated allegations are proven at the hearing by the evidence presented.

Respondent David Roark was at the time of the allegations stated below, licensed as a Professional Nurse in the State of Nevada, and is, therefore, subject to the jurisdiction of the Board and the provisions of NRS Chapter 632 and NAC Chapter 632.

IT IS HEREBY ALLEGED AND CHARGED AS FOLLOWS:

I.

In November and December 2005, Respondent was employed by All About Staffing and working as a Registered Nurse at Sunrise Hospital in Las Vegas, Nevada. During that time, Respondent removed several doses of Lortab 7.5 mg from the Accudose machine for patients that did not have physician's order for Lortab. Respondent did not document administering those medications and did not document wasting those medications. Respondent's actions, in the removal of Lortab without doctor's orders and without documenting the administration of the medication constitutes diversion of the Lortab.

II.

The foregoing conduct constitutes grounds for disciplinary action pursuant to Nevada Revised Statutes 632.320(7) unprofessional conduct, because Respondent violated Nevada Administrative Code 632.890(16) when Respondent failed to document the administration of a controlled substance.

The foregoing conduct also constitutes grounds for disciplinary action pursuant to Nevada Revised Statutes 632.320(7) unprofessional conduct, because Respondent violated Nevada Administrative Code 632.890(18) when Respondent diverted supplies, equipment or drugs for personal or unauthorized use.

Based on the foregoing:

PLEASE TAKE NOTICE, that a disciplinary hearing has been set to consider this Administrative Complaint against the above-named Respondent in accordance with Chapters 233B and 632 of the Nevada Revised Statutes and Chapter 632 of the Nevada Administrative Code.

THE HEARING WILL TAKE PLACE on **Friday, May 19, 2006, commencing at 9:00 a.m.,** or as soon thereafter as the Board is able to hear the matter, at the **Palace Station Hotel & Casino, Grand Ballroom-2nd floor, 2411 West Sahara Avenue, Las Vegas, NV 89102.** This case and other matters are scheduled to be heard by the Board.

PURSUANT TO NRS 632.350, Respondent may request, in writing, that the Board furnish copies of communications, reports, and affidavits in its possession, regarding the above-referenced matter.

As the Respondent, you are specifically informed that you have the right to appear and be heard in your defense, either personally or through counsel of your choice. You have the right to respond and to present relevant evidence and argument on all issues involved. You have the right to call and examine witnesses, introduce exhibits, and cross-examine opposing witnesses on any matter relevant to the issues involved.

You have the right to request that the Board issue subpoenas to compel witnesses to testify and/or evidence to be offered on your behalf. In making this request, you may be required to demonstrate the relevancy of the witness' testimony and/or evidence.

The purpose of the hearing is to determine if the Respondent has violated NRS 632.320(7) and/or NAC 632.890(16) and/or NAC 632.890(18), and if the allegations contained herein are substantially proven by the evidence presented to further determine what administrative penalty is to be assessed against the Respondent, if any, pursuant to NRS 632.320 and/or NRS 632.325 and/or NAC 632.926-.927.

Should the Respondent fail to appear at the hearing, a decision may still be reached by the Board. As the Respondent, you are further advised that you may be charged with cost associated with the hearing pursuant to NRS 622.400.

Pursuant to NRS 233B.121(5), informal disposition of this case may be made by stipulation, agreed settlement, consent order, or default. Any attempt to negotiate this case should be made through Frederick R. Olmstead, General Counsel, Nevada State Board of Nursing.

Pursuant to NRS 241.033(2)(b), the Nevada State Board of Nursing may, without further notice, take administrative action against your license and/or certificate to practice within the State of Nevada if the Board determines that such administrative action is warranted after considering your character, alleged misconduct, professional competence, or physical or mental health.

DATED this 18th day of April 2006.

By: _____

FREDERICK R. OLMSTEAD, ESQ.
General Counsel
Nevada State Board of Nursing
5011Meadowwood Mall Way, Suite 201
Reno, Nevada 89502-6547
(775) 688-2620

NOTICE

Effective July 1, 2005, the Nevada State Legislature amended Chapter 622 of the Nevada Revised Statutes by adding the following provisions:

1. If a regulatory body initiates disciplinary proceedings against a licensee pursuant to this title, the licensee shall, within 30 days after the licensee receives notification of the initiation of the disciplinary proceedings, submit to the regulatory body a complete set of his fingerprints and written permission authorizing the regulatory body to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report.
2. The willful failure of the licensee to comply with the requirements of subsection 1 constitutes an additional ground for the regulatory body to take disciplinary action against the licensee, including, without limitation, suspending or revoking the license of the licensee.
3. A regulatory body has an additional ground for taking disciplinary action against the licensee if:
   (a) The report from the Federal Bureau of Investigation indicates that the licensee has been convicted of an unlawful act that is ground for taking disciplinary action against the licensee pursuant to this title; and
   (b) The regulatory body has not taken any prior disciplinary action against the licensee based on that unlawful act.
4. To the extent possible, the provisions of this section are intended to supplement other statutory provisions governing disciplinary proceedings. If there is a conflict between such other provisions and the provisions of this section, the other provisions control to the extent that the other provisions provide more specific requirements regarding the discipline of a licensee. (Senate Bill 163).

The Nevada State Board of Nursing considers the attached Complaint and Notice of Hearing as the initiation of disciplinary proceedings against a licensee or certificate holder.

Accordingly, please submit, within 30 days after receipt of this notification, a complete set of your fingerprints and written permission authorizing the Nevada State Board of Nursing to forward the fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report.

The willful failure by you to comply with this requirement may constitute an additional ground for the Nevada State Board of Nursing to take disciplinary action against you.

ORIGINAL

BEFORE THE NEVADA STATE BOARD OF NURSING

IN THE MATTER OF DAVID ROARK LICENSED PROFESSIONAL NURSE NEVADA LICENSE NO. RN41470 RESPONDENT	VOLUNTARY SURRENDER OF LICENSE IN LIEU OF OTHER DISCIPLINARY ACTION CASE NO. 1238-05C

I, DAVID ROARK, wish to voluntarily surrender my Nevada Nursing License. I voluntarily and knowingly admit the following facts:

1. I am licensed as a Licensed Professional Nurse in the State of Nevada and I was licensed at the time of the conduct described herein and am, therefore, subject to the jurisdiction of the Board.
2. I admit that during November and December 2005, while working as a Registered Nurse at Sunrise Hospital, I diverted Lortab.
3. I admit these factual allegations constitute grounds for disciplinary action pursuant to NRS 632.320(7), unprofessional conduct, because the conduct violated NAC 632.890 (18) diversion of equipment or drugs.
4. I am aware of, understand, and have been advised of the effect of this Voluntary Surrender.
5. I have read this Voluntary Surrender and I fully understand and acknowledge its facts and terms.
6. I am aware that I have certain constitutional rights, including:
   a. I have the right to hire an attorney to represent me in this proceeding;
   b. I have the right to demand a hearing on the charges against me, and I can require the Board staff to prove the allegations;
   c. I have the right to cross-examine the witnesses against me;

d. I have the right to call witnesses to provide evidence in my own behalf;

e. I have other rights accorded to me under Nevada Revised Statutes Chapters 233B, and 632. Also, I have rights accorded to me under Nevada Administrative Code Chapter 632.

7. I am aware of the foregoing rights, and I voluntarily, knowingly, and intelligently waive these rights in return for the Board accepting my voluntary surrender of my Nevada nursing license in lieu of other disciplinary action.

8. I understand this Voluntary Surrender is considered a disciplinary action and as such will become part of my permanent record.

9. I understand this Voluntary Surrender is considered public information.

10. I understand this Voluntary Surrender is considered a disciplinary action and will be reported to any national repository, which records disciplinary action taken against licensees or certificate holders, or any agency or another state, which regulates the practice of nursing.

11. I understand this Voluntary Surrender may be used in any subsequent hearings by the Board as evidence against me to establish a pattern of behavior and for the purpose of proving additional acts of misconduct.

12. This Voluntary Surrender shall not be construed as excluding or reducing any criminal or civil penalties or sanction or other remedies that may be applicable under federal, state or local laws.

13. I understand that this surrender is effective the day it is accepted by the Nevada State Board of Nursing, or may be effective pursuant to NRS 632.400 (2), however I agree to immediately cease and desist from practicing as a Registered Nurse, and I am returning my license with this signed Voluntary Surrender of License In Lieu of Other Disciplinary Action.

\\\

\\\

I, DAVID ROARK, by my signature affixed below, agree with the foregoing facts and representations and therefore choose to voluntarily surrender my Nevada nursing license.

Dated this 19 day of May, 2006

RESPONDENT
DAVID ROARK

State of Nevada

County of _____

This instrument was acknowledged before me on _____, 2006, by _____

_____.

_____
Notary Public

Accepted and approved this 13th day of June, 2006.

NEVADA STATE BOARD OF NURSING

By: _____
Helen Vos, MS, RN
Board President